

Health,
& Welfare
S. Public
Health Services

S. 300
v. 1-5

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED DEC 9 - 1957

STANDARD CERTIFICATE OF DEATH

42882

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 2983

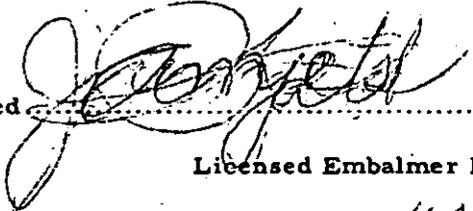
| | | | | | |
|---|------------------------------|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>St. Louis County</u> | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u> | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Clayton</u> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | c. CITY OR TOWN <u>Kirkwood</u> 47130 Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) <u>533 W. Monroe Ave</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| c. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Louis Co. Hosp. 20Dys.</u> Length of stay in lb | | | 4. DATE OF DEATH Month <u>11</u> Day <u>22</u> Year <u>1957</u> | | |
| 3. NAME OF DECEASED (Type or print) First <u>Marie</u> Middle <u>L.</u> Last <u>McCLANAHAN</u> | | | 9. AGE (In years last birthday) <u>42</u> IF UNDER 1 YEAR: Months <u>8</u> Days <u>25</u> IF UNDER 24 HRS. Hours <u></u> Min. <u></u> | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>Col.</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Feb. 27, 1915</u> | 11. BIRTHPLACE (City and state or country) <u>Ferguson Mo.</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u> | | 13. FATHER'S NAME <u>Rev. Grant Edwards</u> | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME <u>Lucy Arnold</u> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u> | |
| 16. SOCIAL SECURITY NO. <u>No.</u> | | 17. INFORMANT <u>John B. McClanahan</u> | | Address <u>533 W. Monroe Av.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>In alimintion</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Carcinoma of Cervix</u> DUE TO (c) <u>= metastasis 171X</u> | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | |
| 20c. TIME OF INJURY Hour <u></u> a. m. <u></u> p. m. <u></u> Month, Day, Year <u></u> | | | 20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 20e. CITY, TOWN, OR LOCATION | | 20f. COUNTY STATE | |
| 21. I attended the deceased from <u>10-30-1957</u> to <u>11-22-1957</u> and last saw <u>her</u> alive on <u>11-22-1957</u> Death occurred at <u>7:50 p. m.</u> on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE <u>Robert M. Lay, M.D.</u> (Degree or title) | | 22b. ADDRESS <u>601 S. Brentwood Blvd.</u> | | 22c. DATE SIGNED <u>11-22-57</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE <u>11/27.57</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Father Dickson Cem.</u> | 23d. LOCATION (City, town, or county) (State) <u>St. Louis Co. Mo.</u> | |
| 24. FUNERAL DIRECTOR <u>John W. Hemphill</u> | | ADDRESS <u>1408 S. Fillmore</u> | | 25. DATE RECD. BY LOCAL REG. <u>11-27-57</u> | 26. REGISTRAR'S SIGNATURE <u>Robert H. Donahue M.D.</u> |

Kirkwood 2c. Mo. (Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by....., Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed .....

Licensed Embalmer No. 44

P. O. Address 4055 Falls

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.